E. Notwithstanding Section 15.040, item A, subitem (4) for rate periods beginning on October 1, 1992, and for rate years beginning after June 30, 1993, the replacement-costs-new per bed limit to be used in Section 15.040, item B, for a nursing facility that has completed a renovation, replacement, or upgrading project that has been approved under the moratorium exception process or that has completed an addition to or replacement of buildings, attached fixtures, or land improvements for which the total historical cost exceeds the lesser of $150,000 or ten percent of the most recent appraised value, must be $47,500 per licensed bed in multiple-bed rooms and $71,250 per licensed bed in a single-bed room. These amounts must be adjusted annually as specified in Section 15.040, item A, subitem (4) beginning January 1, 1993.

F. The Commissioner of the Minnesota Department of Health, in coordination with the Commissioner of the Minnesota Department of Human Services, shall deny each request for new licensed or certified nursing home or certified boarding care beds except as provided under the moratorium exceptions process. "Certified bed" means a nursing home bed or a boarding care bed certified by the Commissioner of health for the purposes of the medical assistance program under United States Code, title 42, sections 1396 et seq.

The Commissioner, in coordination with the Commissioner of the Minnesota Department of Health, shall deny any request to issue a nursing home license to a facility if that license would result in an increase in the medical assistance reimbursement amount.

In addition, the Commissioner of the Minnesota Department of Health must not approve any construction project whose costs exceed ~~$500,000, or 25 percent of the facility's appraised value, whichever is less~~ $1,000,000 unless:

(1) Any construction costs exceeding ~~the lesser of $500,000 or 25 percent of the facility's appraised value~~ $1,000,000 are not added to the facility's appraised value and are not included in the facility's payment rate for reimbursement under the medical assistance program; or

(2) The project:

(a) has been approved through the moratorium exception process described in state law;

(b) meets an exception described in the moratorium exception state law;

(c) is necessary to correct violations of state or federal law issued by the Commissioner of the Minnesota Department of Health;

(d) is necessary to repair or replace a portion of the facility that was destroyed by fire, lightning, or other hazards provided that the provisions of statute governing replacement are met;

(e) as of May 1, 1992, the facility has submitted to the Commissioner of the Minnesota Department of Health written documentation evidencing that the facility meets the "commenced construction" definition as specified in Section 1.030, or that substantial steps have been taken prior to April 1, 1992, relating to the construction project. "Substantial steps" require that the facility has made arrangements with outside parties relating to the construction project and has include the hiring of an architect or construction firm, submission of preliminary plans to the Department of Health or documentation from a financial institution that financing arrangements for the construction project have been made; or

(f) is being proposed by a licensed nursing facility that is not certified to participate in the Medical Assistance Program and will not result in new licensed or certified beds.

G. Prior to the final plan approval of any construction project, the Commissioner of the Minnesota Department of Health shall be provided with an itemized cost estimate for the project construction costs. If a construction project is anticipated to be completed in phases, the total estimated cost of all phases of the project shall be submitted to the Commissioner and shall be considered as one construction project. Once the construction project is completed and prior to the final clearance by the Commissioner of the Minnesota Department of Human Services, the total project construction costs for the construction project shall be submitted to the Commissioner. If the final project construction cost exceeds the dollar threshold in this subdivision, the Commissioner of Human Services shall not recognize any of the project construction costs or the related financing costs in excess of this threshold in establishing the facility's property-related payment rate.

Project construction costs includes the cost of new technology implemented as part of the construction project. "Technology' means information systems or devices that make documentation, charting, and staff time more efficient or encourage and allow for care through alternative settings including touch screens, monitors, hand-helds, swipe cards, motion detectors, pagers, telemedicine, medication dispensers, and equipment to monitor vital signs and self-injections, and to observe skin and other conditions.

The dollar thresholds for construction projects are as follows: for construction projects other than those authorized in subitems (a) to (f), the dollar threshold is ~~$500,000 or 25 percent of appraised value, whichever is less~~ $1,000,000. For projects authorized after July 1, 1993, under subitem (a), the dollar threshold is the cost estimate submitted with a proposal for an exception to the state's moratorium law, plus inflation as calculated according to section 15.1378. For projects authorized under subitems (b) to (d), the dollar threshold is the itemized estimate project construction costs submitted to the Commissioner of Health at the time of final plan approval, plus inflation as calculated according to Section 15.1378.

H. For purposes of this section, a total replacement means the complete replacement of the nursing facility's physical plant through the construction of a new physical plant, the transfer of the nursing facility's license from one physical plant location to another, or a new building addition to relocated beds from three- and four-bed wards.

(1) For total replacement projects completed on or after July 1, 1992, the incremental change in the nursing facility's rental per diem, for rate years beginning on or after July 1, 1995, shall be computed by replacing its appraised value, including the historical capital asset costs, and the capital debt and interest costs with the new nursing facility's allowable capital asset costs and the related allowable capital debt and interest costs.

(2) If the new nursing facility has decreased its licensed capacity, the aggregate replacement cost new per bed limit in Section 15.040, item G, shall apply.

(3) If the new nursing facility has retained a portion of the original physical plant for nursing facility usage, then a portion of the appraised value prior to the replacement must be retained and included in the calculation of the incremental change in the nursing facility's rental per diem. For purposes of this subitem, the original nursing facility means the nursing facility prior to the total replacement project. The portion of the appraised value to be retained shall be calculated according to clauses (a) to (c):

(a) The numerator of the allocation ratio shall be the square footage of the area in the original physical plant which is being retained for nursing facility usage;

(b) The denominator of the allocation ratio shall be the total square footage of the original nursing facility physical plant;

(c) Each component of the nursing facility's allowable appraised value prior to the total replacement project shall be multiplied by the allocation ratio developed by dividing clause (a) by clause (b).

(4) In the case of either type of total replacement as authorized under statutory exceptions or moratorium process exceptions, the provisions of this subitem will also apply. For purposes of the moratorium exception authorized by statutory exception which permits the relocation of 117 beds from a 138 bed nursing home to a former hospital, if the total replacement involves the renovation and use of an existing health care facility physical plant, the new allowable capital asset costs and related debt and interest costs shall include first the allowable capital asset costs and related debt and interest costs of the renovation, to which shall be added the allowable capital asset costs of the existing physical plant prior to the renovation, and if reported by the facility, the related allowable capital debt and interest costs.

I. Notwithstanding Section 15.110, item C, subitem (2), for a total replacement as defined in item H after July 1, 1999, or any building project that is a relocation, renovation, upgrading, or conversion ~~authorized under moratorium process exceptions,~~ completed on or after July 1, 2001, the replacement-costs-new per bed limit are $74,280 per licensed bed in multiple-bed rooms, $92,850 per licensed bed in semiprivate rooms with a fixed partition separating the resident beds, and $111,420 per licensed bed in single rooms. Beginning January 1, 2000, these amounts must be adjusted annually as specified in item E.

J. Notwithstanding Section 15.110, item C, subitem (2), for a total replacement as defined in item H, for a 96-bed nursing facility in Carlton county, the replacement costs new per bed limit for multiple-bed rooms, for semiprivate rooms with a fixed partition separating the resident beds, and for single rooms are the same as in item I. The resulting maximum allowable replacement costs new multiplied by 1.25 constitute the project's dollar threshold for purposes of application of the ~~$750,000~~ $1,000,000 plus inflation limit set forth in state law. The deadline for total replacement of this 96-bed nursing facility is May 31, 2000.

K. Notwithstanding Section 15.110, item C, subitem (2), for a total replacement as defined in item H involving a new building addition that relocates beds from three-bed wards for an 80-bed nursing home in Redwood county, the replacement costs new per bed limit for multiple-bed rooms, for semiprivate rooms with a fixed partition separating the resident beds, and for single rooms are the same as in item I. These amounts will be adjusted annually, beginning January 1, 2001. The resulting maximum allowable replacement costs new multiplied by 1.25 constitute the project's dollar threshold for purposes of application of the ~~$750,000~~ $1,000,000 plus inflation limit set forth in state law. If the other requirements in

state law governing approval of requests for amendments to moratorium exception projects are met, the Department of Health may waive the requirement that the nursing facility's request for an amendment to its moratorium exception project design may not reduce the space in each resident's living area or in the total amount of common space devoted to resident and family uses by more than five percent.

L. For a renovation authorized under moratorium process exceptions for a 65-bed nursing home in St. Louis county, the incremental increase in rental rate for purposes of item D shall be $8.16, and the total replacement cost, allowable appraised value, allowable debt, and allowable interest are increased according to the incremental increase.

M. Effective July 1, 2001, the Commissioner of the Minnesota Department of Health, in coordination with the Commissioner of the Minnesota Department of Human Services may:

(1) license and certify beds in nursing facilities that have undergone replacement or remodeling as part of a planned closure pursuant to Section 19.027;

(2) license and certify a total replacement project of up to 124 beds in facilities significantly damaged in the flood of 1997 when the damage was not apparent until years later. The operating cost payment rates for a new facility are determined pursuant to the interim and settle-up payment provisions of Section 12.000 and the payment provisions of this Attachment, except that Section 11.047, items A and B do not apply until the second rate year after the settle-up cost report is filed. Property-related payment rates are determined pursuant to this Attachment, taking into account any federal or state flood-related loans or grants provided to the facility;

(3) allow facilities that provide residential services for the physically handicapped with less than 60 beds to transfer nine beds to provide residential services, provided that the total number of licensed and certified beds does not increase;

(4) allow non-profit facilities in the county with the fewest beds per 1000 for age 65 and over that are not accepting beds from another closing non-profit facility to build replacement facilities of up to 120 beds, provided the new facility is located within four miles of the existing facility and is in the same county. Operating and property rates are determined pursuant to this Attachment, except that Section 11.047, items A and B do not apply until the second rate year after settle-up; and

(5) allow organizations that operate non-profit facilities in the county with the fewest beds per 1000 for age 65 and over to obtain up to 98 beds of a closing non-profit facility. All transferred beds will be put on layaway status, held in the name of the receiving facility. The layaway adjustment provisions of Section 19.100 do not apply. A receiving facility may only remove the beds from layaway for recertification and relicensure at the receiving facility's current site, or at a newly constructed facility located in Anoka County. A receiving facility must receive authorization before removing these beds from layaway status.

SECTION 15.1375 **Appraisals; updating appraisals, additions, and replacements.**

A. Notwithstanding Sections 15.010 to 15.030, the appraised value, routine updating of the appraised value, and special reappraisals are subject to this section.

B. Notwithstanding Section 15.020, for rate years beginning after June 30, 1993, the Commissioner shall routinely update the appraised value of each nursing facility by adding the cost of capital asset acquisitions to its allowable appraised value. The Commissioner shall also annually index each nursing facility's allowable appraised value by the inflation index referenced in Section 15.040, item A, subitem (4), for the purpose of computing the nursing facility's annual rental rate. In annually adjusting the nursing facility's appraised value, the Commissioner must not include the historical cost of capital assets acquired during the reporting year in the nursing facility's appraised value. In addition, the nursing facility's appraised value must be reduced by the historical cost of capital asset disposals or applicable credits such as public grants and insurance proceeds. Capital asset additions and disposals must be reported on the nursing facility's annual cost report in the reporting year of acquisition or disposal. The incremental increase in the nursing facility's rental rate resulting from this annual adjustment shall be added to the nursing facility's property-related payment rate for the rate year following the reporting year.

Section 15.1376 **Refinancing incentive.**

A. A nursing facility that refinances debt after May 30, 1992, in order to save in interest expense payments as determined in subitems (1) to (5) may be eligible for the refinancing incentive under this Section. To be eligible for the refinancing incentive, a nursing facility must notify the Commissioner in writing of such a refinancing within 60 days following the date on which the refinancing occurs. If the nursing facility meets these conditions, the Commissioner shall determine the refinancing incentive as in subitems (1) to (5).

(1) Compute the aggregate amount of interest expense, including amortized issuance and financing costs, remaining on the debt to be refinanced, and divide this amount by the number of years remaining for the term of that debt.

(2) Compute the aggregate amount of interest expense, including amortized issuance and financing costs, for the new debt, and divide this amount by the number of years for the term of that debt.

(3) Subtract the amount in subitem (2) from the amount in subitem (1), and multiply the amount, if positive, by .5.

(4) The amount in subitem (3) shall be divided by the nursing facility's occupancy factor under Section 15.090, items C or D.

(5) The per diem amount in subitem (4) shall be deducted from the nursing facility's property-related payment rate for three full rate years following the rate year in which the refinancing occurs. For the fourth full rate year following the rate year in which the refinancing occurs, and each rate year thereafter, the per diem amount in subitem (4) shall again be deducted from the nursing facility's property-related payment rate.

B. An increase in a nursing facility's debt for costs in Section 15.1375, item B, subitem (2), including the cost of refinancing the issuance or financing costs of the debt refinanced resulting from refinancing that meets the conditions of this section shall be allowed, notwithstanding Section 15.050, item A, subitem (6).

C. The proceeds of refinancing may not be used for the purpose of withdrawing equity from the nursing facility.

D. Sale of a nursing facility under Section 15.1371 shall terminate the payment of the incentive payments under this section effective the date provided in Section 15.1371, item F, for the sale, and the full amount of the refinancing incentive in item A shall be implemented.

E. If a nursing facility eligible under this section fails to notify the Commissioner as required, the Commissioner shall determine the full amount of the refinancing incentive in item A, and shall deduct one-half that amount from the nursing facility's property-related payment rate effective the first day of the month following the month in which the refinancing is completed. For the next three full rate years, the Commissioner shall deduct one-half the amount in item A, subitem (5). The remaining per diem amount shall be deducted in each rate

year thereafter.

F. The Commissioner shall reestablish the nursing facility's rental rate following the refinancing using the new debt and interest expense information for the purpose of measuring future incremental rental increases.

SECTION 15.1377 **Special property rate setting.** For rate periods beginning on October 1, 1992, and for rate years beginning after June 30, 1993, the property-related payment rate for a nursing facility approved for total replacement under the moratorium exception process through an addition to another nursing facility shall have its property-related rate under Section 15.1370 recalculated using the greater of actual resident days or 80 percent of capacity days. This rate shall apply until the nursing facility is replaced or until the moratorium exception authority lapses, whichever is sooner.

SECTION 15.1378 **Indexing thresholds.** Beginning January 1, 1993, and each January 1 thereafter, the Commissioner shall annually update the dollar thresholds in Sections 15.1373, and 15.1374, by the inflation index referenced in Section 15.090, item A, subitem (4).

SECTION 15.138 **Plant and maintenance costs.** For the rate years beginning on or after July 1, 1987, the Department shall allow as an expense in the reporting year of occurrence the lesser of the actual allowable plant and maintenance costs for supplies, minor equipment, equipment repairs, building repairs, purchased services and service contracts, except for arms-length service contracts whose primary purpose is supervision, or $325 per licensed bed.

SECTION 15.140 **Determination of interim and settle-up payment rates.** The Department shall determine interim and settle-up payment rates according to items A to J.

A. A newly-constructed nursing facility, or one with a capacity increase of 50 percent or more, may submit a written application to the Department to receive an interim payment rate. The nursing facility shall submit cost reports and other supporting information as required in Sections 1.000 to 18.050 for the reporting year in which the nursing facility plans to begin operation at least 60 days before the first day a resident is admitted to the newly-constructed nursing facility bed. The nursing facility shall state the reasons for noncompliance with Sections 1.000 to 18.050. The effective date of the interim payment rate is the earlier of either the first day a resident is admitted to the newly-constructed nursing facility or the date the nursing facility bed is certified for medical assistance. The interim payment rate for a newly-constructed nursing facility, or a nursing facility with a capacity increase of 50 percent or more, is determined under items B to D.

B. The interim payment rate must not be in effect more than 17 months. When the interim payment rate begins between May 1 and September 30, the nursing facility shall file settle-up cost reports for the period from the beginning of the interim payment rate through September 30 of the following year. When the interim payment rate begins between October 1 and April 30, the nursing facility shall file settle-up cost reports for the period from the beginning of the interim payment rate to the first September 30 following the beginning of the interim payment rate.

C. The interim payment rate for a nursing facility which commenced construction prior to July 1, 1985, is determined under the temporary rule then in effect, except that capital assets must be classified under Sections 1.000 to 18.050.

D. The interim property-related payment rate for a nursing facility which commences construction after June 30, 1985, is determined as follows:

(1) At least 60 days before the first day a resident is admitted to the newly-constructed nursing facility bed and upon receipt of written application from the nursing facility, the Department shall establish the nursing facility's appraised value according to Sections 15.010 and 15.040.

(2) The nursing facility shall project the allowable debt and the allowable interest expense according to Sections 15.050 and 15.070.

(3) The interim building capital allowance must be determined under Section 15.080 or 15.090.

(4) The equipment allowance during the interim period must be the equipment allowance computed in accordance with Section 15.100 which is in effect on the effective date of the interim property-related payment rate.

(5) The interim property-related payment rate must be the sum of subitems (3) and (4).

(6) Anticipated resident days may be used instead of 96 percent capacity days.

E. The settle-up property-related payment rate and the property-related payment rate for the nine months following the settle-up for a nursing facility which commenced construction before July 1, 1985, is determined under the temporary rule then in effect. The

property-related payment rate for the rate year beginning July 1 following the nine-month period is determined under Sections 15.000 to 15.140.

F. The settle-up property-related payment rate for a nursing facility which commenced construction after June 30, 1985, shall be established as follows:

(1) The appraised value determined in item D, subitem (1) must be updated in accordance with Section 15.020, item B prorated for each rate year, or portion of a rate year, included in the interim payment rate period.

(2) The nursing facility's allowable debt, allowable interest rate, and allowable interest expense for the interim rate period shall be computed in accordance with Sections 15.050, 15.060, and 15.070.

(3) The settle-up building capital allowance shall be determined in accordance with Section 15.080 or 15.090.

(4) The equipment allowance shall be updated in accordance with Section 15.100 prorated for each rate year, or portion of a rate year, included in the interim payment rate period.

(5) The settle-up property-related payment rate must be the sum of subitems (3) and (4).

(6) Resident days may be used instead of 96 percent capacity days.

G. The property-related payment rate for the nine months following the settle-up for a nursing facility which commenced construction after June 30, 1985, shall be established in accordance with item F except that 96 percent capacity days must be used.

H. The property-related payment rate for the rate year beginning July 1 following the nine-month period in item G must be determined under this section.

I. A newly-constructed nursing facility or one with a capacity increase of 50 percent or more must continue to receive the interim property-related payment rate until the settle-up property-related payment rate is determined under this section.

J. The interim real estate taxes and special assessments payment rate shall be established using the projected real estate taxes and special assessments cost divided by anticipated resident days. The settle-up real estate taxes and special assessments payment rate shall be established using the real estate taxes and special assessments divided by resident days. The real estate and special assessments payment rate for the nine months following the settle-up shall be equal to the settle-up real estate taxes and special assessments payment rate.

SECTION 16.000 PAYMENT FOR REAL ESTATE TAXES AND SPECIAL ASSESSMENTS

The total real estate taxes and actual special assessments and payments permitted under Section 5.000, item CC must be divided by actual resident days to compute the payment rate for real estate taxes and special assessments. Special assessments are reimbursed as paid by the facility except that facilities that incur special sewer assessments as part of their utility bill may reclassify that amount to the real estate tax and special assessment cost category. Real estate taxes are reimbursed based on the real estate tax assessed for the calendar year following the reporting year and are adjusted to account for the difference between the tax year and the reporting year in which the taxes are due. This adjustment is equivalent to ½ the increase or decrease in the property tax liability of a facility. The Commissioner shall include the reported actual or payments in lieu of real estate taxes of each nursing facility as an operating cost of that nursing facility. Allowable costs under this subdivision for payments made by a nonprofit nursing facility that are in lieu of real estate taxes shall not exceed the amount that a nursing facility would have paid to a city or township and county for fire, police, sanitation an road maintenance costs had real estate taxes been levied on that property for those purposes.

SECTION 16.010 **Payment for preadmission screening fees.** The estimated annual cost of screenings for each nursing facility are included as an allowable operating cost for reimbursement purposes. The estimated annual costs reported are divided by the facility's actual resident days for the cost report period. The resulting per diem amount is included in the calculation of the total payment rate under Section 17.000. However, these costs are not included in the calculation of either the care related or other operating cost limits, nor are they indexed to account for anticipated inflation.

SECTION 16.020 **Payment for increase in Department of Health license fees.** A nursing facility's case mix payment rates include an adjustment to include the cost of any increase in Minnesota Department of Health licensing fees for the facility taking effect on or after July 1, 2001.

SECTION 17.000 COMPUTATION OF TOTAL PAYMENT RATE

SECTION 17.010 **Total payment rate.** The total payment rate is the sum of the operating cost payment rate (including any efficiency incentive calculated under Sections 11.030 and 11.040, and the preadmission screening cost per diem calculated under Section 16.010), the property-related payment rate, and the real estate tax and special assessments payment rate. The total payment rate becomes effective on July 1 of the rate year following the reporting year.

SECTION 17.020 **Private payment rate limitation.** The total payment rate must not exceed the rate paid by private paying residents for similar services for the same period. The private payment rate limitation shall not apply to retroactive adjustments to the total payment rate unless the total payment rate being adjusted was subject to the private payment rate limitation.

SECTION 17.030 **Private room payment rate.** A private room payment rate of 115 percent of the established total payment rate for a resident must be allowed if the resident is a medical assistance recipient and the private room is considered as a medical necessity for the resident or others who are affected by the resident's condition except as in Section 15.110, item C. Conditions requiring a private room must be determined by the resident's attending physician and submitted to the department for approval or denial by the Department on the basis of medical necessity.

SECTION 17.040 **Adjustment of total payment rate.** If the Department finds nonallowable costs, errors, or omissions in the nursing facility's historical costs, the nursing facility's affected total payment rates must be adjusted. If the adjustment results in an underpayment to the nursing facility, the Department shall pay to the nursing facility the underpayment amount within 120 days of written notification to the nursing facility. If the adjustment results in an overpayment to the nursing facility, the nursing facility shall pay to the Department the entire overpayment within 120 days of receiving the written notification from the Department. Interest charges must be assessed on underpayment or overpayment balances outstanding after 120 days written notification of the total payment rate determination.

If an appeal has been filed under Section 18.000, any payments owed by the nursing facility or by the Department must be made within 120 days of written notification to the nursing facility of the Department's ruling on the appeal. Interest charges must be assessed on balances outstanding after 120 days of written notification of the Department's ruling on the appeal. The annual interest rate charged must be the rate charged by the Commissioner of the department of revenue for late payment of taxes, which is in effect on the 121st day after the

written notification.

SECTION 18.000 APPEAL PROCEDURES

SECTION 18.010 **Scope.** A provider may appeal from a determination of a payment rate established pursuant to this attachment and reimbursement rules of the Department if the appeal, if successful, would result in a change to the provider's payment rate or to the calculation of maximum charges to therapy vendors under Section ~~20.030~~ 21.030. Appeals must be filed in accordance with procedures in this section.

SECTION 18.020 **Filing an appeal.** To appeal, the provider will file with the Department a written notice of appeal; the appeal must be postmarked or received by the Commissioner within 60 days of the date the determination of the payment rate was mailed or personally received by a provider, whichever is earlier. The notice of appeal must specify each disputed item; the reason for the dispute; the total dollar amount in dispute for each separate disallowance, allocation, or adjustment of each cost item or part of a cost item; the computation that the provider believes is correct; the authority in statute or rule upon which the provider relies for each disputed item; the name and address of the person or firm with whom contacts may be made regarding the appeal; and other information required by the Commissioner.

SECTION 18.030 **Contested case procedures appeals review process.** Effective August 1, 1997, the following apply.

A. Effective for desk audit appeals for rate years beginning on or after July 1, 1997, and for field audit appeals filed on or after that date, the Commissioner shall review appeals and issue a written appeal determination on each appeals item within one year of the due date of the appeal. Upon mutual agreement, the Commissioner and the provider may extend the time for issuing a determination for a specified period. The Commissioner shall notify the provider by first class mail of the appeal determination. The appeal determination takes effect 30 days following the date of issuance specified in the determination.

B. In reviewing the appeal, the Commissioner may request additional written or oral information from the provider. The provider has the right to present information by telephone, in writing, or in person concerning the appeal to the Commissioner prior to the issuance of the appeal determination within six months of the date the appeal was received by the Commissioner. Written requests for conferences must be submitted separately from the

appeal letter. Statements made during the review process are not admissible in a contested case hearing absent an express stipulation by the parties to the contested case.

C. For an appeal item on which the provider disagrees with the appeal determination, the provider may file with the Commissioner a written demand for a contested case hearing to determine the proper resolution of specified appeal items. The demand must be postmarked or received by the Commissioner within 30 days of the date of issuance specified in the determination. A contested case demand for an appeal item nullifies the written appeal determination issued by the Commissioner for that appeal item. The Commissioner shall refer any contested case demand to the Office of the Attorney General.

D. A contested case hearing must be heard by an administrative law judge. In any proceeding under this section, the appealing party must demonstrate by a preponderance of the evidence that the determination of a payment rate is incorrect.

E. Regardless of any rate appeal, the rate established must be the rate paid and must remain in effect until final resolution of the appeal or subsequent desk or field audit adjustment.

F. The Commissioner has discretion to issue to the provider a proposed resolution for specified appeal items upon a request from the provider filed separately from the notice of appeal. The proposed resolution is final upon written acceptance by the provider within 30 days of the date the proposed resolution was mailed to or personally received by the provider, whichever is earlier.

G. Effective August 1, 1997, the Commissioner may use the procedures described in this section to resolve appeals filed before July 1,1997.

SECTION 18.040 **Attorney's fees and costs.**

A. For an issue appealed under Section 18.010, the prevailing party in a contested case proceeding or, if appealed, in subsequent judicial review, must be awarded reasonable attorney's fees and costs incurred in litigating the appeal, if the prevailing party shows that the position of the opposing party was not substantially justified. The procedures for awarding fees and costs set forth in state law regarding procedures for award of fees in contested cases must be followed in determining the prevailing party's fees and costs except as otherwise provided in this section. For purposes of this section, "costs" means subpoena fees and mileage, transcript costs, court reporter fees, witness fees, postage and delivery costs,

photocopying and printing costs, amounts charged the Commissioner by the office of administrative hearings, and direct administrative costs of the Department; and "substantially justified" means that a position had a reasonable basis in law and fact, based on the totality of the circumstances prior to and during the contested case proceeding and subsequent review.

B. When an award is made to the Department under this section, attorney fees must be calculated at the cost to the Department. When an award is made to a provider under this section, attorney fees must be calculated at the rate charged to the provider except that attorney fees awarded must be the lesser of the attorney's normal hourly fee or $100 per hour.

C. In contested case proceedings involving more than one issue, the administrative law judge shall determine what portion of each party's attorney fees and costs is related to the issue or issues on which it prevailed and for which it is entitled to an award. In making that determination, the administrative law judge shall consider the amount of time spent on each issue, the precedential value of the issue, the complexity, of the issue, and other factors deemed appropriate by the administrative law judge.

D. When the Department prevails on an issue involving more than one provider, the administrative law judge shall allocate the total amount of any award for attorney fees and costs among the providers. In determining the allocation, the administrative law judge shall consider each provider's monetary interest in the issue and other factors deemed appropriate by the administrative law judge.

E. Attorney fees and costs awarded to the Department for proceedings under this section must not be reported or treated as allowable costs on the provider's cost report.

F. Fees and costs awarded to a provider for proceedings under this section must be reimbursed to them within 120 days of the final decision on the award of attorney fees and costs.

G. If the provider fails to pay the awarded attorney fees and costs within 120 days of the final decision on the award of attorney fees and costs, the Department may collect the amount due through any method available to it for the collection of medical assistance overpayments to providers. Interest charges must be assessed on balances outstanding after 120 days of the final decision on the award of attorney fees and costs. The annual interest rate charged must be the rate charged by the Commissioner of revenue for late payment of taxes that is in effect on the 121st day after the final decision on the award of attorney fees and costs.

H. Amounts collected by the Commissioner pursuant to this section must he deemed to be recoveries.

I. This section applies to all contested case proceedings set on for hearing by the Commissioner on or after April 29, 1988, regardless of the date the appeal was filed.

SECTION 18.050 **Legal and related expenses.** Legal and related expenses for unresolved challenges to decisions by governmental agencies shall be separately identified and explained on the provider's cost report for each year in which the expenses are incurred. When the challenge is resolved in favor of the governmental agency, the provider shall notify the Department of the extent to which its challenge was unsuccessful or the cost report filed for the reporting year in which the challenge was resolved. In addition the provider shall inform the Department of the years in which it claimed legal and related expenses and the amount of the expenses claimed in each year relating to the unsuccessful challenge. The Department shall reduce the provider's medical assistance rate in the subsequent rate year by the total amount claimed by the provider for legal and related expenses incurred in an unsuccessful challenge to a decision by a governmental agency.

SECTION 19.000 SPECIAL EXCEPTIONS TO THE PAYMENT RATE

Section 19.010 **Swing beds.** Medical assistance must not be used to pay the costs of nursing care provided to a patient in a swing bed unless:

A. The facility in which the swing bed is located is eligible as a sole community provider, as defined in 42 CFR §412.92, or the facility is a public hospital owned by a governmental entity with 15 or fewer licensed acute-care beds.

B. Nursing facility care has been recommended for the person by a ~~preadmission screening~~ long-term care consultation team.

C. The person no longer requires acute-care services.

D. No nursing facility beds are available within 25 miles of the facility.

E. Medical assistance also covers up to ten days of nursing care provided to a patient in a swing bed if: (1) the patient's physician certifies that the patient has a terminal illness or condition that is likely to result in death within 30 days and that moving the patient would not

be in the best interest of the patient and patient's family; (2) no open nursing home beds are available within 25 miles of the facility; and (3) no open beds are available in any Medicare hospice program within 50 miles of the facility.

The daily medical assistance payment rate for nursing care for a person in a swing bed is the statewide average medical assistance skilled nursing care per diem as computed annually on July 1 of each year.

SECTION 19.020 **Contracts for services for ventilator- dependent persons.** A nursing facility may receive a negotiated payment rate to provide services to a ventilator-dependent person if:

A. Nursing facility care has been recommended for the person by a ~~preadmission screening~~ long-term care consultation team.

B. ~~The person has been assessed at case mix classification K (highest rate).~~

~~C.~~ The person has been hospitalized ~~for at least six months~~ and no longer requires inpatient acute care hospital services.

~~D.~~ C. Necessary services for the person cannot be provided under existing nursing facility rates.

A negotiated adjustment to the operating cost payment rate for a nursing facility must reflect only the additional cost of meeting the specialized care needs of a ventilator dependent person. For persons who are initially admitted to a nursing facility before July 1, 2001, and have their payment rate negotiated after July 1, 2001, the negotiated payment rate must not exceed 200 percent of the highest multiple bedroom rate for a case mix classification K. For persons initially admitted to a facility on or after July 1, 2001, the negotiated payment rate must not exceed 300 percent of the highest multiple bedroom rate for a case mix classification K at that facility.

SECTION 19.025 **Special payment rates for short-stay nursing facilities.** For the rate year beginning on or after July 1, 1993, a nursing facility whose average length of stay for the preceding reporting years is (1) less than 180 days; or (2) less than 225 days in a nursing facility with more than 315 licensed beds must be reimbursed for allowable costs up to 125 percent of the total care-related limit and 105 percent of the other-operating-cost limit for hospital-attached nursing facilities. A nursing facility that received the benefit of this limit during the rate year beginning July 1, 1992, continues to receive this rate during the rate year

beginning July 1, 1993 even if the nursing facility's length of stay is more than 180 days in the rate years subsequent to the rate year beginning July 1, 1991. For purposes of this section a nursing facility shall compute its average length of stay by dividing the nursing facility's actual resident days for the reporting year by the nursing facility's total resident discharges for that reporting year.

SECTION 19.026 **Interim closure payments for nursing facilities designated for closure under an approved closure plan and special rate adjustments for nursing facilities remaining open under an approved closure plan.** Instead of payments pursuant to Sections 1.000 to 20.000 or pursuant to the prospective rate-setting methodology in Section 21.000, the Department may approve a closure plan or a phased plan, permitting certain nursing facilities to receive interim closure payments or special rate adjustments.

A. For the purposes of this section, the following have the meanings given.

(1) "Closure plan" means a system to close one or more nursing facilities and reallocate the resulting savings to provide special rate adjustments at other nursing facilities. A closure plan may be submitted by nursing facilities that are owned or operated by a nonprofit corporation owning or operating more than 22 nursing facilities. Approval of a closure plan expires 18 months after approval, unless commencement of closure has occurred at all nursing facilities designated for closure under the plan.

(2) "Commencement of closure" means the date the Department of Health is notified of a planned closure, as part of an approved closure plan.

(3) "Completion of closure" means the date the final resident of a facility designated for closure in a closure plan is discharged.

(4) "Interim closure payments" means the medical assistance payments that may be made to a nursing facility designated for closure in an approved closure plan.

(5) "Phased plan" means a closure plan affecting more than one nursing facility undergoing closure that is commenced and completed in phases.

(6) "Special rate adjustment" means an increase in a nursing facility's operating rates. The special rate adjustment for each facility will be allocated proportionately to the various rate per diems included in that facility's operating rate.

B. The Department will not approve a closure plan or a phased plan unless it determines that projected state savings equal or exceed projected state and county government costs, including facility costs during the closure period, the estimated costs of special rate adjustments, estimated resident relocation costs, the cost of services to relocated residents, and state agency administrative costs relative to the plan. To achieve cost neutrality, costs may only be offset against savings that occur within the same state fiscal year. For purposes of a phased plan, the requirement that costs must not exceed savings applies to both the aggregate costs and savings of the plan and to each phase of the plan.

C. Interim closure payments. To pay interim closure payments, the Department will:

(1) Apply the interim and settle-up rate provisions of Section 12.000 to include facilities covered under this section, effective from commencement of closure to completion of closure;

(2) Notwithstanding Section 15.140, item B, extend the length of the interim period, but no longer than 12 months;

(3) Limit the amount of payable expenses related to the acquisition of new capital assets;

(4) Prohibit the acquisition of additional capital debt or refinancing of existing capital debt unless prior approval is obtained from the Department;

(5) Establish as the aggregate administrative operating cost limitation for the interim period the actual aggregate administrative operating costs for the period immediately before commencement of closure that is of the same duration as the interim period;

(6) Require the retention of financial and statistical records until it has audited the interim period and the settle-up rate;

(7) Make aggregate payments under this section for the interim period up to the level of the aggregate payments for the period immediately before to commencement of closure that is of the same duration as the interim period; and

(8) Change any other provision to which all parties to the plan agree.

D. As part of a phased plan, a nursing facility may receive a special rate adjustment The special rate adjustment may be received under more than one phase of the closure plan, and the cost savings from the closure of the nursing facility designated for closure may be applied as an offset to the subsequent costs of more than one phase of the plan. If a facility is proposed to receive a special rate adjustment or provide cost savings under more than one phase of the plan, the proposal must describe the special rate adjustments or cost savings in each phase of the plan.

(1) The special rate adjustment is effective no earlier than the first day of the month following completion of closure of all nursing facilities designated for closure under the closure plan.

(2) For purposes of a phased plan, the special rate adjustment for each phase is effective no earlier than the first day of the month following completion of closure of all nursing facilities designated for closure in that phase of the plan.

SECTION 19.027 **Planned closure rate adjustments under an approved closure plan.** Between August 1, 2001, and June 30, 2003, the Department may approve planned closures of up to 5,140 nursing facility beds, less the number of licensed beds in facilities that close during the same period without approved closure plans or that have notified the Minnesota Department of Health of their intent to close without an approved closure plan.

A. For the purposes of this section, the following have the meanings given.

(1) "Closure" means the cessation of operations of a facility and delicensure and decertification of all beds within the facility.

(2) "Closure plan" means a plan to close a facility and reallocate a portion of the resulting savings to provide planned closure rate adjustments at other facilities. A closure plan is submitted to the Department by a facility. Approval of a closure plan expires 18 months afer approval, unless commencement of closure has begun.

(3) "Commencement of closure" means the date on which residents and designated representatives are notified of a planned closure as part of an approved closure plan.

(4) "Completion of closure" means the date on which the final resident of a facility designated for closure in an approved closure plan is discharged.